Iowa Department of Human Services

Mental Health System Redesign

Regionalization Workgroup

Discussion Paper # One: Criteria for Formation of Regions

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I. Introduction

Senate File 525 includes a number of criteria or factors to be considered in the formation of regions within Iowa for the purpose of managing non-Medicaid mental health and IDD services. Prior to the enactment of SF 525, there was considerable discussion about whether the Legislature should establish regional boundaries or should establish very specific criteria for regions. For example, one suggestion considered by the Legislature would have mandated that regions be formed around eight metropolitan communities in Iowa.[1]

Ultimately, the Legislature decided to await recommendations from the Regionalization Workgroup before establishing more formal criteria for the formation of Regions. Instead, the Legislature incorporated several factors to be considered in the formation of regions, and the purpose of this discussion paper is to provide some background information and presentation of pros and cons to facilitate the discussions of the Workgroup with regard to these criteria.

Before reaching conclusions or making recommendations about these criteria, it will be important for the Workgroup to return to the discussion of the intended benefits of having regions. Clarity about the potential benefits and down-sides of Regions will provide a useful template for the Workgroup as it evaluates options for the formation of regions.

It should be noted that there is relatively little "science" about the formation of regions. Nor is there a common body of knowledge about "what works and what doesn't work." It seems that the most important factor is for the regional structure to be aligned with and supportive of the overriding policy goals and values of the system. By themselves, regions neither foster nor diminish the quality or effectiveness of a given system. Rather, it the way regions are administered, monitored, and evaluated for performance that ultimately has an effect on their contribution to the overall system.

[1] Ames, Cedar Rapids, Council Bluffs, Davenport, Des Moines, Iowa City, Sioux City, and Waterloo.

II. Goals/Purposes for Regions

The workgroup had an extensive discussion at the August 16, 2011 meeting of the potential pros and cons of regions. Some of the major points of this discussion are summarized in the table below.

Why Regions	Why Not Regions
• Create economies of scale so that scarce resources can be better used for things that consumers and their families really want • Assure easy and equitable access to an array core services • Simplify navigation of the system for both consumers and providers • Provide a clear locus of responsibility and accountability for the quality and effectiveness of services • Reduce complexity and inefficiency in the system • Reduce the duplication of administrative systems and resources • Increase the degree of consistency in service access, delivery and funding throughout Iowa • Maintain the value and effectiveness of local connections and relationships with other systems of importance to consumers and families • Be respectful and responsive to geographic differences within the state • Improve data collection and reporting	• Create another layer of bureaucracy • Create further distance between primary consumers (and their families) and the service system that is supposed to be responsive to their needs and choices • Create geographic or transportation barriers to accessing services • Overlook or overpower the tradition of home rule and local county commitment to services • Create regional barriers or differences in service access and delivery that are similar to those that now exists with the county-based system

III. Specific Criteria

Below are brief discussions of some of the criteria or factors to be considered in the formation of regions. The discussion represents TAC's experiences in other jurisdictions and in Iowa, but should not be assumed to represent either policy recommendations or the position of either TAC or DHS. The purpose is to stimulate discussion and to inform the analysis of options.

A. Size of the population

As noted above, there is no science to establishing population thresholds for regional entities. Even in states with full risk contracts including actuarially determined risk factors based on population, there is wide disparity in the population sizes used. For example, North Carolina has established population

thresholds of 70,000 Medicaid enrollees and 500,000 total population for a region to qualify to participate in a full risk managed care contract. In Michigan, which also has full risk managed care contracts, the population threshold is 22,000 Medicaid enrollees (which would typically mean a total population of about 200,000 people). In Ohio, where the Counties are not managing Medicaid risk contracts, but as with Iowa are managing fixed budgets comprised of local levy and state general fund dollars, some of the mental health boards serve populations as small as 42,000 to 46,000.[2]

Some of the discussions related to Regions in Iowa have mentioned eight to ten regions. If that were the objective of the regionalization process, then the average population of a region would be about 300,000 total people. Only Polk County in Iowa has a population over 300,000.

The population threshold of 300,000 people has been used over the past 20 years as a rough rule of thumb for the population size that can support a full array of services and an adequate administrative structure to assure access, provider quality, consumer choice, diverse provider network, and efficient administrative and business systems. However, as noted above there is no empirical evidence that this population threshold is necessary and many states have successfully employed both larger and smaller regions. For example, a multi-county behavioral health authority in northern Arizona serves a total population of over 700,000 in a geographic area of 62,000 square miles.[3]

The recommendations on population thresholds for regions in Iowa is likely to be based on a number of interrelated qualitative factors. These are likely to include:

- The relative similarity with and success of other types of administrative regions in Iowa;
- The experiences of the three county-based regional groups now working in Iowa;
- The opportunity to coordinate with the formation of Aging and Disability Resource Centers (ADRCs) which will have similar responsibilities and will share some consumers with the MH/IDD systems of care. These ADRCs may also become access points for efforts to re-balance Medicaid expenditures away for restrictive institutional settings and towards more integrated community settings;
- The ability to meet other criteria such as the presence of a CMHC or FQHC and psychiatric inpatient capacity; and
- The process of the workgroup in discussing parameters for “too big” and “too small.”

There is a continuum of factors to be considered in the “too big-too small” discussion. Some of these are suggested in the table below.

[2] Note: only 15 of the 99 Counties in Iowa have total populations greater than 40,000 people.
[3] The total land area of Iowa is 56,000 square miles.

Too Big	Too Small
• Travel time of more than 2 hours from anywhere in the region to the central office (not access points, which presumably will be distributed through all communities in a region, regardless of the size) • Too many counties to form a workable governance board[4] • Potential to become a large bureaucracy, given the span of control and resources commanded • Too distant from consumers, families and providers • Not representative of local geographic and socio-demographic differences and traditions – member counties would not have much in common	• Insignificant economies of scale • Too small for an adequate provider network for core services – not enough consumer choice • In combination with other small regions, too many boundaries for care coordination, and too many entities for providers to bill, etc. • May prevent sharing access to core and specialty services with contiguous counties or regions, thereby reducing opportunities to coordinate care, improve access, etc. • Could make it more difficult to achieve consistency and equity of access throughout Iowa

A major portion of the agenda for the Regional Workgroup meeting next Tuesday will be to discuss and make recommendations on the relative merits and importance of these factors. We will also discuss how the above types of factors could be applied in Iowa.

B. Geographic Proximity and Convenience

There are several factors that could be used to define geographic proximity or convenience. These include:

- Geographic size
- Transportation times between key points within a region
- Presence of a regional transportation authority or service that serves multiple counties
- Congruence of county boundaries
- Reasonable access times to crisis services and other core services

These factors are closely related to the "too big – too small" discussion as outlined above. And, as with the population size discussion presented above, there is no scientific evidence that one approach is significantly better than another. However, there are some rules of thumb which could be employed by the workgroup to test whether a proposed region would be too large or inconvenient. For example, it is common for a state to require access to acute, emergent care within 30 minutes driving time in urban areas and one hour driving time in rural areas. If citizens in a remote county would have to travel more

[4] In North Carolina, some of the regional groups have 20+ counties, making a county-based governance board unwieldy.

than one hour to reach a psychiatric emergency room or urgent care center, then the geographic area might be too large.[5]

It should be noted that states with rural and frontier areas allow for longer travel times, but also emphasize methods for getting services to consumers rather than making consumers travel intro a central locale to receive services. These strategies include mobile clinic services, telemedicine, and reimbursing case managers, ACT team members, etc. for the travel times necessary to reach the homes or work sites of their customers.

Geographic size does not always equate to travel times, particularly in regions crisscrossed by interstate highways. Travel convenience can also be influenced by the presence or absence of regional public transportation or other transportation resources. Travel time, convenience and public transportation access will have to be assessed on a case-by-case basis as the size and shape of regions is considered.

With 99 Counties in Iowa, a population threshold of 300,000 would result in 8 to 10 regions, with a potential average of 8 to 15 counties each. One question for the workgroup is whether consortia of 8 to 15 counties are workable for formation of governance boards or committees, maintaining local interagency collaborations and relationships, and minimizing administrative redundancies. Thus, it is not just population size or geographic distance that should be considered. The workgroup should also consider the number of local political subdivisions that can reasonably be expected to work effectively together to form a region.

C. Natural Service Access and Transportation Patterns

Natural service access patterns typically occur in around an urban core. This is the "hub-and-spokes" phenomena, in which adjacent rural communities may not be as connected to each other as they are to the urban center, with a hospital and several service providers, to which they traditionally go for services. This is one reason for the consideration given by the Legislature to the idea of forming regions around the eight urban centers identified above.

The need to assure the presence of psychiatric inpatient capacity and a CMHC or FQHC in each region also mitigates for a hub-and-spokes approach. However, it is possible that other models, including a consortium of rural counties with no central hub but with good and convenient access to acute care and core services could be formed.

Another factor to be considered is the expansion of Medicaid eligibility for currently uninsured people in 2014. As these individuals and families become enrolled in Medicaid, it will become the responsibility of the managed behavioral health care carve-out entity to assure an adequate provider network of Medicaid services (including acute and inpatient care) for these enrollees. Thus, it can be expected that access to a variety of mental health services will be expanding on the Medicaid side at the same time as the Regions are assuring access to core services for non-Medicaid participants. These activities are likely

[5] Note: access to urgent and emergent care could be provided in adjacent areas, even in other states, under agreement with the region of residence. This does not have to be an absolute criterion.

to be complementary, and thus should make it easier for Regions to assure access and choice of provider within their catchment areas.

The same phenomenon could naturally occur with IDD waiver services, as the state wide wait list, the movement toward self direction, and the expansion of best practice community-based IDD services create incentives for equity of access and more flexible and mobile services. This should result in additional provider capacity and choices that can be incorporated into the regional service arrays and provider networks.

D. Presence of Inpatient Psychiatric Hospital Capacity

This is included as a criterion for regions in SF 525. Thus, any possible combination of counties will have to meet this standard in order to be considered as a region. A map of current inpatient psychiatric facilities, including state Mental Health Institutes, is available on the DHS website.

E. Presence of a CMHC and/or FQHC with Behavioral Health Capacity

This is included as a criterion for regions in SF 525. Thus, any possible combination of counties will have to meet this standard in order to be considered as a region. A list of current CMHCs and FQHCs is available on the DHS website.

F. Can a single county be a region?

Depending on the population threshold determined to be optimal for regions, there may be some counties that qualify to remain as single-county entities. If the threshold is set at 300,000, then only Polk County would qualify. However, if the threshold is set at 100,000, then an additional five counties[6] could qualify to remain as single county entities. The following table presents some of the potential pros and cons of having single county programs.

Pros of Allowing some Counties to Remain as Single County Programs	Cons of Allowing some Counties to Remain as Single County Programs
• Respectful of home rule • Continued strong incentive for these Counties to levy to the maximum[7] • Continued strong incentive for County financial and operational participation in MH and IDD service management, access and coordination with other systems • Continued incentives to maintain best practice and specialty services over and above the defined core services • Strong existing provider relationships could be sustained	• Surrounding counties that now access inpatient, acute care and specialty services within the urban hubs may find it more difficult to access and coordinate care • Surrounding smaller counties may not benefit from the administrative infrastructure and expertise of the core urban county • Natural associations of surrounding counties may be difficult to form, since they may have little in common other than their association with the urban core

[6] Black Hawk, Johnson, Linn, Scott, and Woodbury Counties
[7] This is potentially an obsolete concept

• Strong existing cross system relationships and communications protocols could be sustained	county • If a large single county has county operated services, the perception of conflict of interest in service planning, service access and authorization, consumer choice, etc. would remain. (Note – Joining in a Region could alleviate this perception of conflict of interest)

IV. Conclusion

As noted in the introduction to this issue paper, the discussion of factors and criteria related to formation of regions can be informed by experiences in other systems, but is not grounded in science or thorough evaluations of outcomes and performance. The above materials are presented to guide the discussion and present some issue for discussion. Ultimately, the Regional Workgroup will be seeking a solution that looks and feels right for Iowa, and which presents a reasonable balance between potentially competing factors.

For the purposes of this Workgroup, the number 99 is too high, and the number one is too low. By the end of the meeting on next Tuesday we hope to have arrived at a number and/or set of criteria somewhere between those two ends of the continuum that can meet the needs and choices of all consumers and families in Iowa while at the same time promising to deliver greater consistency, equity of access, and efficient administration for all concerned.